[](https://www.fmlmedical.co.zw/)

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**MEMBERSHIP APPLICATION FORM (Individuals)**

**For administrative use**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MEMBERSHIP NUMBER | | |  | | | PAYER NO. | | |  | | | |
|  | | | | | | | | | | | | |
| COMPANY NAME | | |  | | | | | | | | | |
| **Section 1. CHOICE OF PLAN** | | | | | | | | | | | | |
| PLAN | **Pearl** |  | |  | **Garnet** | |  |  | |  |  |  |

**Section 2. DETAILS OF PRINCIPAL MEMBER**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TITLE |  | | | | | | | | | | | | | | | | | | | |
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| FIRST NAME(S) |  | | | | | | | | | | | | | | | | | | | |
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| SURNAME |  | | | | | | | | | | | | | | | | | | | |
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| GENDER |  | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |
| MARITAL STATUS | Single | | | Married | | | | Divorced | | | | | Widowed | | | | | | Other | |
|  | | | | | | | | | | | | | | | | | | | | |
| ID NUMBER |  |  | - | |  |  |  | |  |  |  |  | | - |  |  |  |  | |  |
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| DATE OF BIRTH |  | | | | | | | | | | | | | | | | | | | |
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| EMAIL |  | | | | | | | | | | | | | | | | | | | |
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| POSTAL ADDRESS |  | | | | | | | | | | | | | | | | | | | |
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| PHYSICAL ADDRESS |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| CELL NUMBER |  | | | | | | | | | | | | | | | | | | | |

Date from which membership is supposed to commence**:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Section 3. DETAILS OF DEPENDANTS TO BE INCLUDED**

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| Adult rates apply to any dependant who is 18yrs or older. Child rates apply from newly born babies to full time students aged  18-24yrs provided proof of education for the current year is attached to the application form. Acceptance of the dependants will be in accordance with the Rules of the Scheme**.** |

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**Section 4. DECLARATION OF MEDICAL HISTORY**

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| Do you or any of your dependants suffer from any of the following medical conditions? If yes, tick the appropriate box and provide details below. | | | | | | | | | |
| **Diabetes** |  | **Hypertension** |  | **Arthritis** |  | **Asthma** |  | **Bone problems** |  |
| **Heart problems** |  | **Cancer** |  | **Renal/Kidney disease** |  | **Abdominal problems** |  | **Orthodontics** |  |

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| **Name of dependant** | **Name of condition** | | **Name of medication** | **Currently receiving treatment? Y/N** | | | **Date diagnosed** | **Attending Doctor** |
|  |  | |  |  |  | |  |  |
|  |  | |  |  |  | |  |  |
|  |  | |  |  |  | |  |  |
| Are you or any of your dependants pregnant? | | | | | | | | |
| **Name of dependant** | | **Expected date of delivery** | | | | **Attending Doctor** | | |
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**Section 5. PREVIOUS MEDICAL INSURANCE** (Please attach membership certificate showing termination date)

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| **Name of Medical Aid Scheme** | **Plan/Package** | **Membership No.** | **Date of Registration** | **Date of Termination** |
|  |  |  |  |  |

Are you changing your medical aid due to change of employer? If yes, please provide a letter from previous employer confirming termination of employment and date.

**Section 6. EMPLOYER/ACCOUNT HOLDER INFORMATION**

This section MUST be completed by the Employer/Account holder. No application form will be processed without the Employer/Account holder authorisation signature or stamp.

**Name of Employer/Account holder**

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| --- |
|  |

**Employer Account No**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employee EC No.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Aid Start Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employment Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the Scheme Rules and Plan chosen. All sections of the application form have been completed.

**Employer Telephone No.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorisation Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 7. BANKING DETAILS FOR REFUNDS**

Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Branch Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Branch Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Account Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Principal Member**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**TERMS AND CONDITIONS ON APPLICATION FOR MEMBERSHIP**

This form should be completed by first time applicants to First Mutual Health or if you were a dependant and now wish to be a member in your own right. If you are a member of First Mutual Health and wish to add or remove a dependant or change from one Plan to another, complete the Membership Update Form.

Please complete all the sections of this application form as it forms the basis for your registration.

**Section 1 Choice of Plan**

First Mutual Health offers a variety of Plans. Please the appropriate box for the Plan you wish to join. Your employer should approve the Plan choice if you are joining through a company.

**Section 2 Details of Principal Member**

The personal details of the principal member should be entered here. Settlement advice slips and cheque refunds will be made out to this person. Please enter the personal details as they appear on your identity document as you may be asked to produce this along with your membership card when you see providers of health services.

**Section 3 Dependants**

May include your spouse, your children, or in certain circumstances other dependants the member wishes to benefit from the Scheme. The Scheme may request a medical report before accepting other family members as dependants. Relationship to member describes the relationship of the dependant to the principal member. Spouse and child are normal dependants anyone else e.g. parents, in-laws etc is considered to be an “other dependant”. A child aged between 18 and 24 years may be classified as a student provided they are studying full-time and proof of education for the current year is attached to the registration form. Otherwise such a child will be classified as an “adult dependant”.

**Section 4 Declaration of Medical History**

You need to inform the Fund, if you, or any of your dependants you are registering, is currently undergoing, or likely to require medical treatment. It is very important that you disclose all information as failure to do so will be a breach of contract leading to failure to have claims settled.

**Section 5 Previous Medical Insurance**

Please provide a membership certificate with termination date if you are moving from another medical aid Fund. If you are changing employer, please provide a letter confirming termination of employment and date.

**Section 6 Employer /Account Holder Information**

This section should be completed by the person who will be responsible for remitting your contributions to First Mutual Health either the Individual account holder, or your employer designated officer. Employers need to stamp the form and sign as authorisation for applicant to be on the First Mutual Health Scheme. The account holder number is the number which appears on the billing invoice. If you are applying for membership without Employer affiliation you should submit a completed Employer/ Individual Account Holder application form along with your membership application. The Employer account number is automatically generated by First Mutual Health, please remember to quote the number each time you remit your contributions.

**Start date** is the effective date from which the membership wants to be registered and benefit. Membership runs from the first day of the month to the last day of the month. Applications must be received before the 25th day of the month for registration to be effective from the 1st of the following month.

**Section 7 Banking Details of Principal Member**

Please provide First Mutual Health with your banking details to enable the payment of claims refunds, low claims bonus or cash back through Electronic Funds Transfer (EFT).

**Contribution Payments:**

Please note that contributions are paid a month in advance. If contributions are not received for a period of ninety (90) days the membership will be terminated.

**DECLARATION**

I declare that the information contained in this form is materially true in all respects. I agree that should my application for membership be accepted, I will abide by the Rules, Benefits and Regulations set by First Mutual Health from time to time. I certify that none of my dependants suffer from any condition/s not declared. I authorise the deduction from my salary of the monthly contributions due in respect of my dependants and myself. Signing this application form, forms the basis of a contract between myself and First Mutual Health.

**I acknowledge that should I terminate my membership before the medical benefit becomes payable there will be no refund of contributions**

Signature of Principal Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

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